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THE SOCIAL AND REHABILITATION Record

Resource Planning ★ New Books ★ Computerized Service Systems ★ HMO's and Medicaid ★ Cuban Refugees ★ Research and Demonstration ★ Career Opportunities ★ Volunteer Power

Social and Rehabilitation Service

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Volume 1/Number 2/February 1974

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THE SOCIAL AND REHABILITATION
Record

Volume 1, Number 2 February 1974

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PHOTOS: Page 14, Charles Moore (Black Star); F. Zagarino (Black Star); Page 18, F. Zagarino (Black Star); Page 20 SRS; Page 27, Michael D. Sullivan; Page 29, 30, 31, ACTION.

Connecticut leads in providing decentralized service

Upon visiting Connecticut's Regional Center for Retardation recently, Fred J. Krause, Executive Director, President's Committee on Mental Retardation, praised the State as a leader in providing decentralized services for the retarded people of Connecticut. He made the statement at a meeting with Governor Meskill who has been appointed to the 21-member Presidential committee.

The State is recognized as a national leader in developing small, community-based centers and in reducing the population of training schools for the retarded.

A good example of this emphasis is the Manefield Training School which has reduced its rolls from 2,100 to 1,100 inhabitants during the past 5 years. Most of the retarded population in this instance has been resettled into area communities where they can function and learn in the everyday setting of the community.

To help it further its program, the school has received an SRS community alternative and institutional reform grant. The $90,000 grant is effective for 2 years.

Trust territories now eligible for VR funds

In the western eye, the vision of Pacific islands tends to be idyllic: swaying palms, stretches of fine beach sand, easy living. Topographically, of course, the vision is nearly true. But wherever people live, the ills that they are heir to beset them. It is no different in the Trust Territories (TT) of the Pacific (Micronesia) which is administered by the U.S. under a trusteeship agreement from the United Nations. The 150,000 people of TT live on some 100 islands (in a colorful confetti of 2,141 islands and atolls) that cover 3 million square miles in the Pacific Ocean, roughly equivalent to the land mass of the continental U.S.

Through Region IX administration, an SRS-sponsored research and demonstration team in 1971-1972 asked themselves this sobering question: How do you go about starting a vocational rehabilitation program in a country where there is not: 1) an indiginous word to describe it, 2) a social concept to explain it, 3) a cultural acceptance to nurture it, 4) an economic base to support it, or 5) professionals to administer it?

To answer this complex question, the team determined the kinds of prevalent handicapping conditions, numbers of affected persons, and the geographic locations of these disabled people. Additionally a survey of existing community resources was conducted, and how service delivery could be effected was considered.

The second year of the study was devoted to further research, planning for a program, and implementation of the plans. A vocational rehabilitation State plan and a manual of operations (applicable to all six TT districts) was written. Community resources, available locally and in Guam and Hawaii, were further investigated. A 6-month training program for indigenous persons was developed.

All of this planning and preparation was going on under "temporary funds." Regular funding for such a program was earmarked under vocational rehabilitation legislation. But on September 16, 1973, President Nixon signed the Vocational Rehabilitation Act of 1973 which allots $627,920 to the Trust Territories for an ongoing vocational rehabilitation program. To earn this amount, the TT would need to provide $156,905 for matching these federal funds. Inclusion of the TT as a "State" also makes it eligible for innovation and expansion grants under Section 120 of the Act.

At any rate, the groundwork has been laid for a vibrant program in this remote area of the world. As the people from the Eastern Caroline Islands would say: "Kaselehlia." It means "Hello," and it means "Goodbye." But in either case, it has the implication of "glad to know you" and "Here's to the future."

New England gears for energy crisis

State welfare administrators in New England recently briefed Region I SRS personnel on their plans to meet the energy crisis. Their chief concern is that welfare recipients and low income families will suffer extreme hardships.

Major oil dealers are tightening credit, so cash on delivery or in advance will be required for purchases. Varied plans or proposals are being considered by the States to solve this payment dilemma. Here are some of them:

Maine is contemplating the establishment of a fuel assistance fund and possibly implementing a Title IV-A emergency assistance program.

Rhode Island's new flat grant program includes automatic increases in fuel allowances when the price rises 10 percent.

Vermont is waiving the income level tests for general relief. Low income families will be given extra funds when they have expended their

regular fuel allowance. For categorical recipients, the welfare department is increasing its fuel budget by 50 percent during the months of December through March.

New Hampshire may try to devise a means of fuel cost relief through the emergency assistance program for AFDC. The counties and municipalities will assume responsibility for meeting hardships, insofar as possible.

Massachusetts Commissioner Minter strongly supports the concept that the emergency assistance option of Title IV-A be used to provide the initial buffer to higher fuel prices or else to pay for a family's entire fuel budget for the season.

Connecticut's Commissioner Norton would consider an emergency assistance program later on for families, if in fact a real heating fuel crisis develops. Comment was made that OEO may establish some kind of a revolving fund to assist clients with heating costs. Norton believes that guaranteed State credit for rising fuel costs and not increasing flat grants is the key issue at this point.

Maine and *Rhode Island* recommended 100 percent federal funding for additional fuel needed by all low income families and adults under the emergency assistance program.

Placement results from RSA projects

Rehabilitation Services Administration funded projects with industry are coming into their own in many ways, including the demonstration that rehabilitation organizations can work directly with industry in a symbiotic relationship.

More than 1,000 clients were served in fiscal year 1972 by the 10 projects in operation. Better yet, nearly 65 percent of these clients were placed in competitive industry.

Placements, also, generally were a notch above the usual. For example the Vocational Guidance and Rehabilitation Service in Cleveland is training clients for employment as technicians in the optical industry.

Over 100 private industries are cooperating with the 10 projects in providing specialized and on-the-job training. Many of the clients, as a result of these special arrangements, have been placed in these industries.

Iowa Adapts National system to monitor service

The reciprocal rehabilitation reporting system (RRR) for rehabilitation facilities has stimulated Iowa State rehabilitation facilities specialists and rehabilitation facility personnel toward an innovative adaptation of the data provided by the system. Analysis of the data also has provided the opportunity for a determination of the extent to which the system meets their specific needs.

Introduced in 1967 by the Rehabilitation Services Administration, RRR produces two types of reports by member agencies: 1) a case service report which supplies basic client information on the nature and cost of services rendered and 2) the annual report which gives information on physical plant, accreditations, staff, services, and finances of facilities.

In 1969, Iowa facilities staff reviewed the RRR system and found that it provided necessary basic data, both on facilities and clients, of benefit to statewide rehabilitation facility planning efforts. Disadvantages were that the data was compiled nationally *only* on cases *closed* and the system was voluntary. After consultation with RSA, Iowa reduplicated the already developed RSA form, but added a fourth carbon page. Upon *entry* of the State client, the facility was *required* to fill out the form. The added copy was sent to the State office where it provided data on clients currently in facilities. This made possible the tabulation of statistics on client service during a fiscal year or any other time period.

Although initially beset by problems, primarily in developing manpower for monitoring and keeping statistics up to date, Iowa has been able to develop effective feedback, including provision of tabulated data to rehabilitation facilities. During the past year, the information received was evaluated also in terms of additional information needed, information gathered which is not pertinent, and methods of utilizing the data.

RSA is presently reviewing the entire system of the collection of facility information. Iowa, facilities staff members from other States, and representatives of rehabilitation facilities will have the opportunity to utilize their experience with the RRR system and to participate in developing a model client/facility information system which will provide:

For rehabilitation facilities: A management tool that can be used to evaluate the goals and objectives of the facility in regard to client characteristics such as disability, geographic location, outcomes, etc., as well as providing valuable data for public relations and for financial negotiations with referral and revenue sources.

For State vocational rehabilitation agencies: Better identification for revenue sharing purposes, data on client productivity level or growth patterns, and identification of fee and support resources so that the State agencies will be able to document the levels of coordination and cooperation involved in the integration of services.

Matching Resources With Your Priorities

ALLEN HODGES, PH.D.

When general revenue sharing started, one Western State received $16 million. Out of curiosity, I asked an official of that State how the money would be used.

"Dividing it up will be no problem," he assured me. "We will get the department heads around a table and ask each one how much he needs."

"What if the health department, and the education and welfare departments each ask for the entire $16 million?" I asked. "How are you going to set your priorities?"

"Well," my friend replied, "we will just stay there at the table and pare the requests down."

As most social service administrators are only too well aware, it is in this kind of give and take game that funding decisions are made all around the country. Departments most always have priorities. But generally a firm data base is lacking to justify those priorities. The factual knowledge to make a rational case for funding one program over another usually just isn't available.

We have never had what could be called a system—and this is true of the Federal Government, too—for assessing in an objective fashion the service needs of particular populations and subpopulations. Too often administrators have had to rely on guesswork or have allowed vocal pressure groups to set priorities. Even worse, they have seen money go to the district which "voted right" in the last election, not necessarily to the district which had the greater need.

Establishing priorities is only part of the problem. We also lack a system for measuring the effectiveness of programs once in operation.

In an effort to remedy this "assessment gap," the University of Denver's Center for Social Research and Development has undertaken a prototype study under project director Parker Oborn. It has compiled health, ethnic, education, welfare, economic, and demographic data for each county in Region VIII's six States and rank orders each county in relation to other counties in the State. A further objective is to develop statistical indices that will, hopefully, isolate the relationships, if any, between infant mortality and the educational level of a county, or infant mortality and community ethnic makeup.

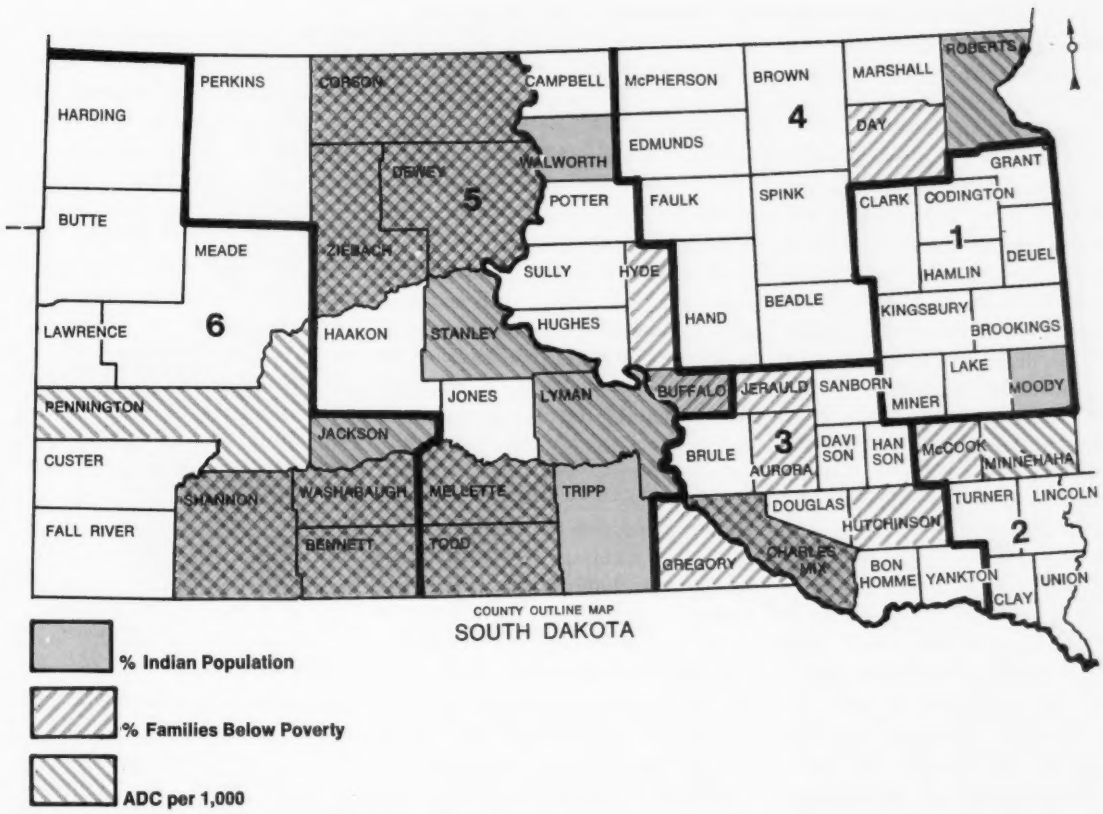
Progress so far shows the promise of its developing a reliable "profile of needs" for particular populations within the Region VIII States of North Dakota, South Dakota, Montana, Wyoming, Utah, and Colorado.

What the Denver University Center has done, for example, is to rank order all 63 of Colorado's counties on the basis of 189 variables, chosen from more than 750 that were considered. Space is not available here to list them all. But the 189 variables selected are pretty much what one would expect: death rates by heart disease, cancer, accident, suicide, infant mortality; population groupings by age, race, income, fertility rate; the rates of marriages and divorces; the rates of unemployment and the percentage of families receiving public assistance or welfare; the ratio of doctors, dentists, and nurses; the school population and educational attainment levels by age groups; and also the average annual rainfall and length of growing season.

To illustrate how this rank ordering system might work, assume that I am running a family planning program. The ranking of counties by fertility rate indicates that in Colorado the highest rates are in the southern counties (heavily populated by Spanish-speaking Roman Catholics) and in the mountains where the people are poor and isolated.

Let's say we tentatively decide to concentrate our program efforts in the 10 counties with the highest rates. Some people will argue that this is a pretty crude approach. They will point out that Archuleta County, which ranks seventh in fertility, has only 8,000 residents, while the city of Denver has 350,000 people. Even though the fertility rate is low in Denver, they will contend that we will get to more sheer numbers of people by concentrating our efforts in Denver.

Of course, this is the way a great



Relationships among three variables are shown. Note that Moody and Tripp Counties show high Indian populations, but do not rank among top 25 percent in either below poverty level or ADC rates per 1,000, important focus for progam planners. Similar observations may be made by combining any of the 121 socio-economic variables.

many activities have been justified for years in HEW. But let's take a closer look. If we add up the people in the 10 top counties, we find that there are a total of 50,000, compared to a high fertility population of 70,000 in Denver. This comparison greatly sharpens our perspective; we can begin to ask tougher questions and make a more rational justification of priorities to determine how and where to deploy our family planning efforts so the neediest counties are not ignored.

We must remember that in the above instance we were dealing with only one variable. And that, admittedly, is a crude approach. But we can take our analysis of need another step further by bringing in other variables.

For example, for the first time we can attempt to answer "What is the *relationship* between the median educational level of a county and infant mortality? What is the relationship between educational level and the

number of children on Aid for Dependent Children?" The project data allows us to undertake correlations in this area, and the tentative results are somewhat surprising.

Infant mortality is generally considered a health problem. But our correlations show that statistically it is as much related to the educational level of a community as to the number of resident doctors and nurses. In a county where the level of education is low, there appears to be more infant mortality, regardless of the health care availability factor. The crucial variable might be just the sheer ability to read a newspaper to learn the need for prenatal care and where to obtain it.

In several counties with large Spanish-American populations, there are high infant mortality rates. Some of these counties also have high dropout rates from secondary schools, although dropout rates generally are greatest in the mountain counties, where there are relatively few Spanish-American residents. Educationally, counties with high concentrations of Spanish-American residents tend to be 2 or more years below State average in school year attendance.

So the interrelationships can be analyzed and with this type of analysis one can select the counties where there is an apparent need for an adult education program, supplemented with some public health education in the hope of reducing infant mortality. Incidentally, high infant mortality also correlates with the number of AFDC children. Here, then, is another potential target population for infant mortality prevention. If programs were developed to concentrate on those AFDC pregnant mothers in terms of prenatal care and to increase their general education and public health knowledge levels, it no doubt would be possible to significantly alter the infant mortality profile of any county.

There is another side of the priority assessment coin, and that is accountability, measuring the effectiveness of programs. With our data base of 189 variables kept updated year to year, we will be able to maintain a much closer check on project outcomes.

For example, we will be able to obtain a base rate in County X and decide to reduce the population on welfare by a certain percentage compared with 1969-70. Next year we can go back and say: "We put special emphasis on County X; we spent x number of dollars on a demonstration project and several SRS service integration projects. Did we reduce the number of people on welfare?"

We have not attempted to do this yet, but we now have the beginning yardstick to attempt this and, to Region VIII's knowledge, this is the only system within HEW to answer such specific impact questions.

Another very timely use for this system is in connection with special revenue sharing to States. The Federal Government is planning to give block grants to the States and allow them to set their own priorities concerning where to allocate the money. But how are the States going to do it? The Federal Government is telling the States to come up with hard data for setting priorities when it doesn't have a priority data base of its own!

The nutrition program for the aging is an example of this problem. It requires the States to establish priorities and rank communities within the States. With the availability of the Region VIII socioeconomic demographic data for each State, this is a relatively easy task. Counties can be ranked on the number of older people, the percentage of minorities, and poverty levels. More variables can be included to refine priorities further.

With special revenue sharing for education, to cite another example, the same approach is possible. The Governor could look at the percentage of high school dropouts by county. In Colorado, he could see that counties with the highest dropout rates cluster in the high mountains.

While such an analysis indicates where dropout prevention and rehabilitation programs might be initiated, there may be a catch. My hunch is that a good many of those 16- and 17-year-olds in the mountains are leaving school early to take jobs at ski resorts and in the lumbering industry. So here is perhaps another variable that should be investigated.

What the statistics do tell us to look at much closer is the entire issue of school dropouts. Dropout rates may not always be an index of poverty, particularly in rural mountain counties.

In stating these examples, I can hear the project people out in the field complaining that utilization of socioeconomic data analysis to set priorities can lead to mistakes. They

can imagine the management people in the State capitals and in Washington evaluating this data incorrectly and perhaps not bothering to consult with them as to how they see priorities in the field. Who knows better what should be done, the data or the man in the field?

The answer to this issue is that you need both. You need information from the field to cross-check the data and vice versa.

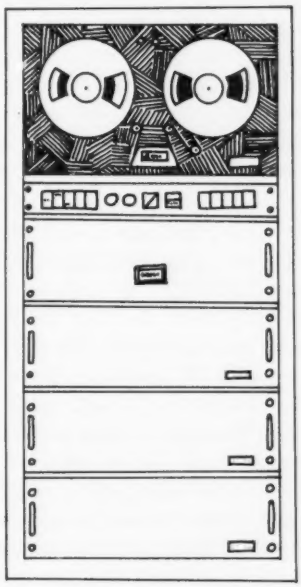
Obtaining good data and keeping it updated every year is, of course, fundamental to drawing reliable socioeconomic profiles. The Denver University Center gets its information from State tax bureaus, the State health, education and welfare departments, employment security divisions, industrial marketing manuals—any source where data is collected annually on a county-by-county basis. In our initial attempt, about half of the data came from the U.S. Census Bureau, but its usefulness is limited because it reflects only 10-year trends.

The center has encountered certain trouble spots. Many Colorado counties, for example, don't report deaths by cirrhosis of the liver, thus making it hard to estimate an alcoholism problem. It is very difficult to get good data on juvenile delinquency.

Five Colorado counties have no physicians at all; in 30, there is no doctor of optometry; 15 have no dentist and 26 have no sanitarian. As a result, a lot of material has to be eliminated because it isn't typical of all 63 counties in the State.

There are critics who say some of the data is inaccurate. If this is true, our feeling is that the statistics should be thrown out or made more reliable, or proven that they are unreliable. Literally millions of dollars go into the collection of data every year by State departments. They should either collect reliable data or stop such costly efforts.

When you are dealing with 189 variables, the sheer number is overwhelming. The center has put them all into a computer, and it is using a process known as "factor analysis" to cluster the variables with the hope of distilling the 189 to a more manageable number.



Preliminary analytic study suggests that the counties which are doing poorly economically have high incidences of welfare families, high AFDC, high infant mortality, and a low general education level.

A unique factor which appears to characterize some rural counties is the *style of life* resulting from usable land. In these counties you find good grazing land, good farming, good mining and oil production, and a style of life quite different from the poor rural counties sitting on top of a mountain where there is no farming, mining or cattle raising.

Project efforts are also undertaken to develop a method by which counties in different States can be compared across State lines. For example, with limited migrant health funds we can determine where the migrants are, something we've never known before. If the application is made for Colorado's San Luis Valley, we can compare the number of migrant workers there with the number in Utah. This provides a regionwide method in establishing priorities.

There is still another advantage to this system which may be the most important of all. We have made the data available to the counties so their officials can see for themselves where each county stands in the rank ordering of variables. Many are discovering that they qualify for assistance in areas which they were not aware of. They now have the information on which to decide whether to go after a particular grant.

Dr. Hodges is Assistant Regional Director for Planning and Evaluation in HEW's Region VIII since 1970.

Medicaid's Answer for Better Service: HMO's

PAUL S. HUGHES

Total direct health care expenditures for Americans in fiscal year 1973 was approximately $80 billion. Eighteen billion dollars (23 percent of this amount) were attributable to the two largest federal health programs—Medicare (administered by the Social Security Administration) and Medicaid (administered by SRS). The combined Federal-State expenditures under the Medicaid program alone were over $9 billion, of which approximately $5 billion were paid by the Federal Government. For the most part, health services for which these sums were paid were delivered under a fee-for-service system which is the predominant method of reimbursement for case services.

Questions have been raised whether there were ways of improving the delivery of health services to Medicare and Medicaid eligibles which may be more cost-effective than the present system.

One alternative which has been proposed to achieve this improvement is the use of health maintenance organizations (HMO's). Although all the evidence is not in on their cost and utilization effects, sufficient evidence does exist to indicate that they have the potential to provide continuous comprehensive care at the same or at lower cost than that being provided by the existing fee-for-service health delivery system.

An HMO may be viewed as an organized system of health care which accepts the responsibility to provide, or otherwise assure, the delivery of an agreed upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons in a specific geographic area. Also it is reimbursed on the basis of prenegotiated, periodic payments that are made by or on behalf of the enrollee and/or his dependents. The essence of this definition by Roger W. Birnbaum is found in his paper, *Prepayment Neighborhood Health Centers: Guidelines for the Planning of or Conversion to a Health Maintenance Organization.*

Advantages to the HMO enrollee are that he has a single source through which he receives all of his (or his family's) medical care, his primary physician is responsible for his case even if he is referred to a specialist or is hospitalized, and that for a fixed payment he is insured against most catastrophic illnesses. Since revenue is fixed, the HMO has the incentives to maintain the enrollee's health to avoid large health care expenditures and to use the most economical methods of care.

Such a system is, therefore, *both* a delivery and a financial mechanism. For third party payors, such as State Medicaid agencies, an HMO has the additional advantage of permitting the payor to budget forthcoming expenditures accurately and predictably.

A wide variety of public and private organizations, such as general hospitals, medical societies, consumer groups, health insurance carriers, group practicing physicians, medical schools, private employers, unions, and federally-funded comprehensive health centers, acting singly or in combination, may sponsor HMO's. This diversity is deliberate in that it

permits each locality to tailor systems suited to its particular needs and resources.

The HMO movement is not new in this country. Its concept has been evolving from the formation of group practices as early as 1883, when the Mayo Clinic was established. Prepaid group-practice plans date back to 1929 when the Farmers' Union Cooperative Health Association was started in Elk City, Oklahoma. Following on the heels of this effort was the formation and growth of approximately 30 prepaid group plans (Gordon K. Mac Leod, M.D., and Jeffrey A. Prussin. "The Continuing Evolution of Health Maintenance Organizations." *New England Journal of Medicine*. March 1, 1973).

They included such plans as the Ross-Loos Medical Clinic in Los Angeles in 1929 (102,000 enrollees); Group Health Association in Washington, D.C., in 1937 (85,000 enrollees); the Kaiser-Permanente Medical Care Programs in 1942, which are located in six areas of the country but concentrated on the West Coast (2.5 million enrollees); the Group Health Cooperative of Puget Sound in Seattle in 1947 (170,000 enrollees); the Health Insurance Plan of Greater New York in 1947 (780,000 enrollees); and the Group Health Plan of Minneapolis in 1957 (50,000 enrollees).

By 1973 these plans, along with the growth in recent years of medical care foundations sponsored by county medical societies, have led to the availability of HMO alternatives to approximately 7 million Americans. This represents about 3 percent of the national population.

The HMO concept received increased national attention with the inclusion of the HMO initiative in the President's 1971 Health Message to Congress. By June 30, 1973, the Department of Health, Education, and Welfare had invested approximately $30 million in research, development, evaluation, and technical assistance in over 100 organizations. Many of these became operational during this period.

During this period a section in Title XIX of the Social Security Act (the enabling legislation for the Medicaid program) was relatively unnoticed. It permitted eligible persons to obtain Medicaid assistance from qualified medical care providers, including organizations which provide such services or arranges for their availability on a prepayment basis [Title XIX, Section 1902(a)(23)].

In June 1971, consistent with the President's initiative, SRS awarded 15 grants totaling $1.1 million. These were aimed at obtaining information regarding the cost-effectiveness of HMO care for Medicaid beneficiaries, assisting in feasibility and development studies for developing HMO's which would include Medicaid enrollees, and learning the most appropriate marketing strategies and enrollment techniques for integrating a Medicaid group into an HMO.

Of the 15 HMO grants, 2 were for the creation of innovation units in State Medicaid agencies, 8 for feasibility and developmental studies (including 1 devoted exclusively to marketing) aimed at developing viable HMO's serving Medicaid enrollees, and 5 for evaluating comparative costs and utilization effects for HMO and fee-for-service Medicaid beneficiaries.

The evaluation projects, in particular, are providing valuable information on such subjects as perceived health status, medical care and drug utilization patterns, recipient costs, recipient satisfaction, consumer participation efforts, and outreach techniques. One project has provided quantitative evidence that Medicaid hospital admission rates and inpatient stay rates were reduced by 56 percent and 45 percent respectively, while drug utilization rates were reduced by 39 percent after Medicaid eligibles enrolled in the HMO. The Preliminary results indicate that the HMO costs ranged from 8 to 20 percent less than comparable services provided on a fee-for-service basis.

Reacting to these results and the prospects for additional useful evaluative information, Medical Services Administration (MSA) officials encouraged State Medicaid agencies to experiment with the HMO concept as an alternative to the present reimbursement system. By June 30, 1973, 12 States had signed contracts with 54 HMO's, with a total Medicaid enrollment of 270,000 person.

In October 1972, the President signed P.L. 92-603 which permitted Medicare beneficiaries to elect to receive covered services through capitation payments to an HMO (Section 226). As part of this section, the Secretary of HEW was authorized "to provide at the request of any State (and without cost to such State) such

technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of section 1876 . . ." (Section 226(e)).

The Medical Services Administration adopted a three-pronged strategy for implementing this provision. First, in June 1973, it entered into a 1-year pilot contract effort to provide Section 226(e) assistance in two States. This contract is providing MSA with the requisite experience in contracting for technical and actuarial assistance prior to broad-scaled implementation. The knowledge gained and the material developed during the pilot effort will enable future technical assistance contracts to be completed in less time and at a lower cost per State to the Government.

The second part centered on making interim assistance available through cooperative arrangements with other HEW agencies which currently had consultants under contract who were capable of delivering such assistance. The Bureau of Community Health Services responded by making several man-months of their contractors' time available in each of the 10 HEW regions.

A nationwide conference was held in September 1973 to announce MSA's interest in expanding the number of Medicaid eligibles afforded an opportunity to enroll in HMOs, to allow State Medicaid agencies to benefit from each other's experience in contracting for HMO services for their recipients, and to make States aware of available interim assistance.

The third phase is concerned with providing this form of technical assistance to the States on an as-needed basis. Based on the pilot experience to date, arrangements are presently being made to fund such an effort from available resources. It is anticipated that the mechanism for this will have been completed in time to coincide with the termination of the interim assistance.

In a speech before the American Public Health Association in San Francisco on November 5, 1973, Secretary Caspar W. Weinberger stated that the HEW position regarding HMO's was one of being "committed to major support for the HMO concept as an alternative to the traditional fee-for-service approach, but it is not our intention to force any single system of health care on anyone." This approach creates more health care resources from which Medicaid eligibles may choose. Furthermore, it permits the States to contract with medical delivery systems which are the most cost effective.

The Medical Services Administration is no longer concerned merely with funding demonstrations to test the feasibility or develop the organization of HMO's. As MSA Commissioner Howard N. Newman pointed out in his speech at the HMO conference in September 1973, the answers are not all in, either about the ultimate cost-effectiveness of HMO's or about some of the components that should (or should not) go into them. As a result, MSA will continue to participate in evaluation studies to obtain more detailed answers on these questions, particularly as they affect the poor.

MSA officials feel, however, that sufficient experience has been gained to suggest to States that they may want to make this alternative available to some of their Medicaid-eligible population. Furthermore, States which recognize the potential of HMO's should be helped to utilize the experience of others so as not to "reinvent the wheel" in negotiating capitation contracts for their recipients. MSA is seeking to increase to over a million persons the number of Medicaid recipents who have an opportunity to enroll in HMO's. It is anticipated that within a year the number of State Medicaid agencies that have signed contracts with at least one HMO will increase from 12 to 20 and that the number enrolling Medicaid recipients will expand from 54 to over 80.

The accomplishment of these objectives will require the combined efforts of central and regional office personnel of several HEW agencies and a willingness by State officials to consider alternatives to their present methods of provider reimbursement. As Commissioner Newman urged in a speech to the National Conference for Developing Title XIX-HMO Contracts (Miami, September 1973): "the necessary improvement of health services for the poor through more efficient use of our health resources makes this worth our best efforts."

Mr. Hughes is Acting Chief, Health Delivery Systems Branch, Office of Program Innovation, MSA, SRS.

Publications and Films

The Editors of the SOCIAL AND REHABILITATION RECORD regularly receive notification of the release of new publications and films of interest to readers.

Each issue of the RECORD will carry a selected list of these publications and films with brief discriptions of their contents.

Please address all inquiries and requests to the addresses given in this listing.

Program Evaluation: A Beginning Statement. Rehabilitation Services Administration, SRS/DHEW, Washington, D.C. 20201. 89 pages.

The Tenth Institute on Rehabilitation Services has developed this basic study on program and service evaluation as a guide for State vocational rehabilitation agencies. The document examines the methods and goals of program evaluation and encourages further investigation and follow-up in this area.

Vocational Evaluation and Work Adjustment Services in Vocational Rehabilitation. Materials Development Center, Dept. of Rehabilitation and Manpower Services, University of Wisconsin-Stout, Menomonie, Wisc. 54751. 92 pages. $1.

Presented from the perspective of a vocational rehabilitation counselor, this Tenth Institute on Rehabilitation Services publication considers the definitions, objectives, techniques, and utilization of vocational evaluation and work adjustment services.

A checklist guide for each vocational rehabilitation process is also included as a summary of the major conditions, programs, and practices.

Animals in Signs. 48 pages. $2 and **Home in Signs.** 48 pages. $2. Frank Caccamise and Carolyn Norris. Alinda Press, P.O. Box 553, Eureka, Calif. 95501.

Any simple unassuming coloring book places a great deal of power in the hands of a young child—to create green sky, blue trees, orange faces, magenta hands. These particular coloring books are no exception; yet, in them is found an added dimension of power and influence. Their illustrations and signs of basic household and animal words present a hearing impaired child with a means of more fully communicating with his daily environment.

The first two books in a series of such educational materials, they are designed to involve the child, his family, and friends in the "total approach" method of furthering the deaf child's language development.

In addition to the signs and their descriptions, the books include the manual alphabet and numbers, signs for colors, and several frequently used verbs and adjectives.

Securing the Legal Rights of Retarded Persons. Elizabeth Ogg. 381 Park Ave. South, New York, N.Y. 10016. 28 pages. $.35.

The legal and civil protection rightfully due the mentally retarded in this country is the topic discussed in this Public Affairs pamphlet. The publication offers the reader a concise view of the denied opportunities and obstacles with which society confronts the mentally retarded individual; it also indicates certain methods by which citizen groups may overcome these social and illegal barriers.

The Role of Facilities in Training Rehabilitation Personnel. James E. Trela, editor. Research Department, Vocational Guidance and Rehabilitation Services, 2239 East 55th St., Cleveland, Ohio 44103. 216 pages. $.50.

It has been demonstrated throughout the field of rehabilitation that a growing need exists for an increase in the number of trained rehabilitation personnel. Although several options are open with regard to the educative process, this collection of papers focuses on the use of facilities as a training ground for rehabilitation personnel. The facilities would offer individual trainees the advantage of an experiential setting, in addition to providing ready opportunity for interaction with State agencies, colleges, and universities.

The papers and accompanying recommendations are presented from the different perspectives of State administrators, facility administrators, practicing counselors, university educators, and facility based trainers.

Proceedings: International Symposium on the Rehabilitation of the Industrially Injured. Workmen's Compensation Board of British Columbia, 5255 Heather St., Vancouver 13, B.C., Canada. 101 pages. $6.50.

A 4-day conference sponsored by Workmen's Compensation Board of British Columbia in cooperation with Rehabilitation International was held in Vancouver in April 1973. Many of the participants' papers are included. The selected articles investigate such areas as: organic brain damage, industrial diseases, spinal cord injuries, amputations, the world's need for basic rehabilitation services, public relations and roles in rehabilitation.

Films

Troubled Campers. 16 mm. Black and white. 16 min. Wediko Films—Documentaries for Learning, 267 West 25th St., New York, N.Y. 10001, and International Tele-Film Enterprises, 221 Victoria St., Toronto, Ontario, Canada. Sale, $125. Rental, $10.

The treatment of emotionally disturbed children in a New Hampshire camp setting is the subject of this documentary. In addition to presenting an objective view of these children, the film surveys the overall structure and rationale of the program. It also raises many discussion-provoking questions concerning aide programs in general for behavior disordered young people.

Public Attitudes toward the Physically Disabled. 90 min. Video. (sizes—1/2" Sony tape, 1" Bell and Howell, 3/4" Sony cassette tape, and 2" high band for commercial broadcasts) Research Dept., Curative Workshop of Milwaukee, 10437 West Watertown Plank Rd., Milwaukee, Wisc. 53226. $10.

A 4-month seminar supported by the Wisconsin Humanities Committee and focusing on the public's reaction to the handicapped is the foundation for this video tape film. Specifically, the film presents a group of severely physically disabled individuals discussing and confronting the problem of public attitudes

To Live With Dignity. Color. 29 min. University of Michigan Television Center, 310 Maynard St., Ann Arbor, Mich. 48108. Sale, $200. Rental, $15 for the first day and $5 for each additional day.

The successful design of a Michigan Institute of Gerontology special project for treating disoriented elderly people is documented in this film. It notes positive changes in the patients' attitudes as they partake in therapy and self-care activities.

It is designed for staffs of nursing homes and of geriatric wards in mental hospitals as a way of showing how the institutionalized elderly may recover their self-sufficiency and dignity.

America's Record of Service for

For centuries a highway of migration to the New World, the Straits of Florida have been a focal point of conflict in the Western Hemisphere. Havana, capital of Cuba, located to the south of the Straits, has been the site of warfare and siege, conquest and surrender since the 1500's.

But in January 1959, Havana experienced a new phenomenon in the person of Fidel Castro. The "bearded one" had moved down from the mountains and, with surprisingly little difficulty, soon imposed a reign of terror on the Cuban people. Gradually, an exodus from Cuba began. In the 2-year period from January 1959 to January 1961, 50,000 Cubans crossed the Straits of Florida by air and sea to seek refuge in the U.S. These refugees were the forerunners of a half million more to follow.

The refugee movement has continued for 14 years, supported by the U.S. Government. Freedom has been achieved, though with a sacrifice that cannot be measured. The Straits of Florida contain the remains of thousands who fled in small boats and rafts and died in shipwrecks or of thirst or starvation.

The first refugees were those in active political opposition to Fidel Castro. Soon, however, it becaue evident even to the ordinary Cuban businessman that life under the new regime meant confiscation, harrassment, and worst of all, loss of freedom. Thus, by mid-1961, refugees

or Cuban Refugees

MANUEL R. GIBERGA

coming to the U.S. from Cuba represented a broader range of occupations—from banker and college professor to semiskilled workers and students. By the fall of 1962, Cuban refugees came to represent all classes—poor and once rich, professionals and laborers, housewives, plumbers, factory workers, and fishermen. In common, they had a love for freedom, a will to endure the unknown perils of exile, and the desire to put their knowledge and skills to work. Highly motivated, faced with an uncertain future, still dreaming of a free Cuba, the exiles nevertheless faced life realistically and found jobs of any kind, at any rate of pay. Thus they began the process of repaying the U.S. hospitality by constructive economic efforts in all fields.

It became evident in early 1961 that the flow of refugees would not diminish. In the tradition of providing asylum for the oppressed, President Kennedy directed the Secretary of Health, Education, and Welfare to undertake a nine point Cuban Refugee Program (CRP), which called for the following:

1. Providing all possible *assistance to voluntary relief agencies* in furnishing daily necessities for needy refugees, for resettling as many refugees as possible, and for securing jobs for them.

2. Obtaining the assistance of both private and governmental agencies to provide useful *employment opportunities* for displaced Cubans, consistent with the overall employment situation in Florida.

3. Providing funds for the *resettlement* of refugees to other areas.

4. Furnishing *financial assistance* to meet basic maintenance requirements of needy Cuban refugees in the Miami area and, as required, in communities of resettlement.

5. Providing for essential *health services* for the refugees.

6. Furnishing federal assistance for local public *school operating costs* in the Miami area.

7. Initiating measures to augment *training and educational opportunities* for Cuban refugees.

8. Providing financial aid for the care and protection of *unaccompanied children,* the most defenseless and troubled group among the refugee population.

9. Undertaking *surplus food distribution* to needy refugees.

By the time commercial flights from Cuba were stopped, during the Missile Crisis in October 1962, a total of 153,534 refugees had been registered by the Cuban Refugee Center in Miami. It was the end of two commercial flights a day carrying refugees from Cuba to Miami. It ushered in a period of disillusionment and hopelessness among the potential refugees remaining in Cuba. Many chose to start across the Straits of Florida in small boats. The lucky ones arrived on the shores of the United States.

The massive influx of refugees having slowed to a trickle, the Cubans in exile here settled down to face the future. The situation in Miami was bleak. The city was in an economic slump and jobs were few. The language barrier led to underutilization of skills. Sixty thousand refugees were receiving emergency welfare payments. Families were separated. In most cases, the wage earner was still in Cuba. In Miami alone there were over 8,000 women, most with small children, whose husbands had been forced to remain in Cuba. Nationwide, there were over 13,000 unaccompanied children in foster care situations. Resettlement by the CRP offered the only substantive hope.

CRP was successful in moving large numbers of people to various States, in spite of their general reluctance to move from the Miami environment. The climate, which so closely resembled that of Cuba, the company of their fellows in exile, and the recurring hope of a free Cuba and ability to return to their homes—all these factors held the refugees in Miami.

Faced with an uncertain future in a foreign land, they saw no alternative but to work and thus regain a place in society. While they worked, most endeavored to study either English or other subjects that would improve their job potential. With the aid of the CRP, these opportunities were made available through the Dade County Board of Education in Miami

and through professional associations and universities throughout the U.S.

The results were spectacular. In a number of States, universities offered education courses and graduates were placed as Spanish teachers. In Iowa, for example, 38 of 99 counties had at least one Cuban exile teaching Spanish. In Indiana, 20 of 92 counties were utilizing Cuban refugees as Spanish teachers. By January 1965, the University of Miami had trained more than 100 teachers for positions in the State of Florida and elsewhere. The Miami course is still in operation.

By January 1965, commercial flights from Cuba to the U.S. having been terminated for nearly 2½ years, over 7,000 persons in 806 boats had successfully negotiated the Straits of Florida. Thousands had not succeeded, either because of interception by Cuban patrol boats or because of natural hazards.

Meanwhile, in Miami, the CRP had begun to phase out its operations. By the spring of 1965, the phaseout was well along in its implementation.

But on September 28, 1965, Castro publicly announced: "Anybody who does not like the way we run the country can just pack up and go."

In reply to Castro's statement, President Johnson said: "I declare to the people of Cuba that those who seek refuge here will find it. The dedication of America to our traditions as an asylum for the oppressed will be upheld."

Thus, a new influx of refugees began to reach Miami via a "Cuban Refugee Airlift," established by the U.S. under an agreement with Cuba. Beginning December 1, 1965, and ending April 6, 1973, 3,048 airlift flights carried over a quarter million Cubans to the U.S. They were received at Freedom Gate near Miami and, while awaiting reunion with their relatives, were housed in a dormitory facility aptly named Freedom House.

Though the mechanics were relatively simple, the operation was incredibly complex. Originally, the refugees came from a list of applicants for departure compiled in Cuba, the "Cuban Master List." Names were sent to the United States so that the families wishing departure from Cuba could be cleared for entrance by the U.S. Immigration Service. Once cleared, the names were returned to Cuba. The applicants were then theoretically allowed to leave the country by the Cuban Government.

Later, a so-called "American List" was compiled from applications of American citizens who were claiming relatives in Cuba. In these cases, the individuals in Cuba were cleared by the Immigration Service before the lists were sent to Cuba. At that point, their departure was dependent on the Cuban Government.

The exodus had many problems. Military age male youths were not allowed to depart. Thus many families were split. Other families decided to remain in Cuba with their sons. Later, various other restrictions, such as requiring those who wished to depart to work in the sugar harvest prior to departure, were imposed by the Cuban Government. In any case, all property was taken over by the Cuban Government without reimbursement and the refugee was not allowed to bring any valuables other than a single suitcase with what clothes he possessed.

Nevertheless, the refugees came north, seeking the American dream and finding it—in Miami or in other areas of their choice. *Los Vuelos de la Libertad* (the Freedom Flights) carried out the promise of the President of the United States. The flights were terminated only when the Cuban Government could no longer furnish people "qualified to leave."

To the Cuban refugee arriving in Miami after the harrowing experience of leaving the country he or she loved, the CRP became a focal point for a number of very deep and tender emotions. It offered a compassionate welcome with tenderness and a first taste of freedom after a long period of oppression. The refugee was greeted in his native tongue; his needs and desires were ascertained; he was whisked through immigration formalities, through the registration process, and into the voluntary agency of his choice. If rejoining a relative out of Miami, he was housed in a transient facility, then ushered to the airport for the flight to his waiting family in a distant city. If rejoining relatives in Miami, he joined them immediately after visiting the voluntary agencies.

Everywhere he was greeted with warmth and able to exchange gossip with those employees of the CRP who still had relatives in Cuba and were hungry for information about them and their homeland.

After the minimum formalities were concluded, most Cuban refugees

never saw the refugee center or its employees again. It nevertheless remained a source of sympathy and recourse if trouble came, a place where there was someone to talk to and to offer counsel if the need arose.

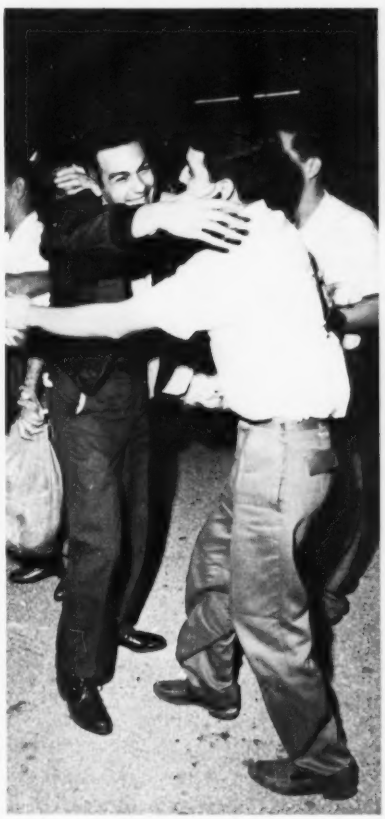
To a small minority (mostly the aged) who did not have the resources or the ability to make their way on their own, the CRP extended educational, financial, and medical aid as a part of the comprehensive program set forth by the Federal Government in 1961 and implemented by HEW.

The Office of Education, Public Health Service, and SRS (the primary implementing agency) contributed skill and expertise to utilize effectively the financing generously voted by Congress each year after the influx of refugees began.

But the arriving Cuban refugee, though welcomed and helped by the U.S. Government, faced the same kind of experiences immigrants to this country have always faced. The language barrier presented difficulties in a variety of areas. Applying for a driver's license, signing a contract for leasing an apartment, appearing in court for a traffic violation, watching television, reading a newspaper, talking to a neighbor, expressing a political viewpoint—all these situations become struggles because of language differences.

HEW recognized the language problem early, and the response of the CRP in providing for training in English as well as in vocational skills has been outstanding. The training has been comprehensive and thorough.

In the Miami area, the Dade County Board of Education has given full cooperation to the effort. Adult night classes were expanded as the need for conducting English language classes for Cuban refugees was recognized and federal financing became available. Refugees who had been teachers in Cuba were recruited as teachers' aides and paid with federal financing.



As the need became apparent, a special center offering courses in English and vocational skills was set up to provide training for Cuban women who had come to the United States with their children, but whose husbands were forced to remain in Cuba. Over 8,000 of these women were trained and placed in permanent jobs. They have not been back on the welfare rolls.

Because Dade County had little industry and an oversupply of Cuban workers, the CRP initiated, at the onset of the program, a policy of resettling any willing Cuban refugees to other parts of the United States, where jobs were more plentiful. From the viewpoint of the Cuban refugee, the resettlement policy was the most controversial part of the CRP. Most refugees wanted to remain in Miami.

The resettlement policy was and is probably right, however, because it introduced the refugees to all parts of the U.S., provided better job opportunities, and relieved the Miami community of some of the pressure the oversupply of workers had caused. Indeed, in parts of New Jersey and, to a lesser extent, in other areas of the United States, the Cuban environment has been transplanted and is flourishing.

Only a relatively small number of the refugees resettled during the life of the CRP have returned to Miami because their resettlements have broken down. The greatest factor in the breakdowns that have occurred has been loneliness, although climate has often also played a part.

Even among resettled refugees who make a good adjustment, however, a pattern leading back to Miami has developed. After acquiring a skill, a

license to practice, or a comfortable savings account, refugees often return to Miami by choice, buy houses, and practice their skills.

For needy refugees, the special welfare and medical aid programs administered by the State of Florida and the Dade County Public Health Service have worked well. As the need has declined, the programs are being regularized and brought under the jurisdiction of the financial assistance programs of the various States. This transfer is part of the planned phaseout of the CRP.

For 12 years the CRP has received and resettled Cuban refugees. It has stood as a symbol of the friendliness and freedom of the United States. Through the program and the voluntary agencies under contract to it, refugees have been brought directly to the shores of the U.S., without preliminary screening in a third country. Three quarters of a million refugees came by boat or by the aerial bridge to settle in Miami or elsewhere in the U.S. Now, with the end of the airlift, plans call for the CRP to be phased out during the next few years. Perhaps this is the proper time to analyze what has been done, why it was done, and whether it could have been done in a better way.

The problem facing the U.S. Government in 1961 was that large numbers of people were coming into a strange land without the means to communicate in the language of the land or to make a living. The people had no resources of their own. They were from all walks of life and of every age and description. The situation in 1961 was chaotic and promised to grow worse as Cuban refugees flooded Miami. It called for extreme measures to cope with the destitute already in the city and to meet the challenge of the increasing influx.

The CRP was created to meet these needs by working with a variety of organizations—governmental, religious, and private. It was not designed to deal directly with the refugees as a separate agency.

Under the CRP plan, HEW contracted with Florida's Division of Family Services, the Dade County Government, and the Dade County Board of Education. These organizations had the capability to provide the resources necessary to deal with specific aspects of the problems encountered by the refugees. At the same time, resettlement funds were provided by contract with the U.S. Catholic Conference, the International Rescue Committee, Church World Service, and HIAS (the Jewish agency).

As a result, the Federal Government's direct contact with the refugees was limited to reception and registration functions. Other federal functions included setting standards, maintaining records, and coordinating the work of contractors.

The decision to contract out operational functions has worked well. The contracting organizations performed efficiently and stimulated other nonprofit organizations across the country to assume many supportive activities. Efficient and inexpensive, the contract program eliminated the need for creation of a new bureaucracy, which would have been difficult to phase out when the need for the program ended. Already, CRP personnel has been reduced by 71 percent. The reduction in staff has been accomplished without undue hardship to either the Federal Government or to the individual.

In addition, the CRP has achieved the humanitarian goals set forth by President Kennedy at its inception in 1961. Statistical criteria prove this success in a variety of ways—but statistics can prove anything. The real test for the success of any refugee program is the ultimate result—whether the refugees have achieved viable places in the society into which they have fled. The answer for CRP is a resounding "Yes."

The success of the adjustment of the Cuban refugee to his new way of life can be observed in all parts of Dade County. Cubans are found at all levels of business, in every profession, throughout the skilled trades, and in many government jobs. Most Cubans now receiving financial assistance are aged, disabled, or blind.

The CRP initiated a WIN program before WIN was developed, controlled and audited welfare rolls through data processing 10 years ago, and was able to reduce the financial assistance rolls by two thirds in a 2-year period. In summary, the program displayed innovative management techniques seldom matched in the history of American Government.

Mr. Giberga is Vice Chairman, Advisory Council, Cabinet Committee on Spanish Speaking People.

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Software System for Human Services

ROBERT KIRK WALKER

Not too long ago, as representatives of several human services agencies in the Chattanooga area were meeting, the discussion turned to a woman with grown children who had moved from agency to agency most of her adult life. No agency had ever recommended her for a physical examination. One was ordered promptly.

The examination revealed that she was suffering from minor brain damage that could be effectively treated.

The woman is representative of literally millions of people with real needs who frequently are swapped from one agency to another.

In Chattanooga, however, and in its surrounding 13 counties, we have found a path out of the wilderness. Our approach has been to combine supportive services, such as outreach, recruitment, intake, assessment, referral, followup, finance, and even transportation for 98 public and private agencies in the area. Their activities can be coordinated, controlled, and evaluated effectively with a real-time computer system, equipped with communications terminals that make pertinent information available to specific inquiries.

At present, the system contains information about 35,000 clients in Greater Chattanooga. We soon will add data about an additional 30,000. The results already produced by this new capability are impressive.

For example, we now are able to provide faster emergency service for clients, backed by an objective followup concerning the *quality* of the service. The system supports a coordinated program of tests, examinations and evaluation and a tailored long-range program for each client.

Moreover, it generates an automatic followup to assure that the client stays with his assigned program. Daily, weekly, and monthly reports are generated automatically as a by-product of system processing. This helps evaluate and summarize services rendered.

The objective, of course, is ultimate self-sufficiency for those clients who have a potential for achieving it, and maintenance with dignity for those who are unable to be on their own.

The goals of the program are being achieved to a degree never before possible—at least in our area—*because the computer system facilitates full coordination of services.* This has helped us to better meet individual needs, since no one agency provides all the client services required. It also has enabled us to reduce costs.

While lost potential of humans has been the greatest waste generated by the old welfare system, the greatest direct monetary waste has not been due to "chiseling" by recipients. It has been due, rather, to the high cost of administration and personnel.

Without coordination, for example, 10 workers from 10 agencies might have visitied John Doe's house to ask him essentially the same questions, a process that would be quite destructive to his meager store of dignity. In addition, the multiplicity of visits and questions and the fragmentation of agency responsibility would have meant that no one saw his or the family's total problem.

Since each worker's perspective is different and since he would have only partial information on family units, none was able effectively to treat the true source of the problem.

Now, since all requests for services and responses to followup efforts can be entered into the computer system, we can better see and treat the *total* problem as well as evaluate the effectiveness of the treatment administered—either by a single case worker at an agency or an entire agency. As a result, Chattanooga now can report to each agency on how well it is performing. This type of reporting simply was not possible before. Consequently, the city can now better apportion the funds it controls to the truly effective agencies.

In addition, reports on agency

activities produced by the computer—an IBM System/370 Model 145—undergo continuous review by the city's Office of Evaluation and Management, headed by Madison M. McBrayer, former Inspector General for the Strategic Air Command. This office evaluates special categorical grants, block grant programs, and internal operations within the Mayor's office. Within the first few weeks after it was established, the office enabled us to revamp certain purchasing procedures within agencies and save $100,000 a year.

We encountered some resistance to the new human services system from agency heads at first, primarily due to lack of understanding. But today, their attitude is cooperative. Moreover, area and regional offices of many of the federal programs are encouraging us to move further in this direction, with possible eventual consolidation into a Department of Community Development.

The Chattanooga system is an outgrowth of a 14-city pilot demonstration program, sponsored by the U.S. Department of Housing and Urban Development and the Department of Labor. It started in 1967. One of its goals was to coordinate federally-funded projects administered at the local level. By 1969, the city's efforts resulted in the development of a basic computer system for sharing general information among agencies that served the same clients. While the concepts were valid, there were serious limitations: the system was oriented toward paperwork, not readily accessible computer displays, for sharing and retrieving data.

Shortly after taking office in April 1971, we reviewed a 500-page, multivolume report analyzing our local problems with federal programs. The central theme was that *cooperation* was often obtainable, but *coordination* was still virtually impossible. Observation, discussion, and study led us to conclude that in the field of human services we were faced with the following difficulties: authority was fragmented; priorities were unclear; planning was uncoordinated; communication was lacking; and the need for change was recognized at the national, regional, and local levels, particularly among those persons directly responsible for the operation and implementation of the programs on the local scene.

Federal programs are big business, a $40-million-a-year activity in the Chattanooga area. It was obvious that it must be managed in a business-like manner, particularly because the end product is the most precious one of all—the care of human life. Thus, in the fall of 1971 we began a major effort to develop an effective, online system to help solve an urgent local problem.

We inaugurated the new system on May 1, 1972, with 12 display terminals located in the city's three neighborhood centers. These are basically central intake, outreach, referral and followup centers. The terminals are used to enter, update, and retrieve information from the computer about clients, agencies, and their services. Each center also has a typewriter-like terminal used to print service plan requests. One center has four additional terminals for use in responding to telephone inquiries from agencies that do not have terminals.

Based on the system's initial success, we received an HEW grant for $357,000 for the 1st year of a 3-year project to expand the information system to more than 500 human resource agencies in 13 nearby counties. Ultimately, we plan to add terminals at key points throughout the region as the counties are ready to go online to the system.

We can foresee tremendous economic and social benefits nationally if the approach can be adopted by other cities across the country. The key to our concept is not the computer, of course, but a consolidation of human services made workable by the computer. To illustrate how the system operates:

When an applicant visits one of the neighborhood centers operated by the Human Services Department, he fills out a simple personal history form. Then, using a visual display terminal which resembles a TV set with a keyboard, an operator feeds the applicant's data into the information system and it is entered via telephone lines onto the computer's disk storage unit at City Hall.

Meanwhile, the applicant describes his problem to an emergency counselor who selects the agency to help him. This is also keyed into a terminal. The operator receives a screen display of the exact services the agency offers, selects the specific ones most appropriate for the applicant, and presses a button. An adja-

cent hard-copy printer terminal produces a "Client Agency Service Plan," setting forth basic information about the applicant and the service desired. The applicant takes the request with him in one of the radio-dispatched vans and presents it to the agency selected.

One week after the initial meeting, the system automatically produces an "outreach" request to remind an outreach staff member from the center to visit the client and follow up on the service. Information the worker reports after the visit includes the client's comments, which become a key factor in the evaluation process. His comments are stored in the computer and ultimately included in one of the reports evaluating the agency and its personnel.

The outreach worker also schedules the recipient for another visit where he is counseled by a trained social worker. The social worker may suggest aptitude tests and/or a physical examination and, perhaps, skills training. Again, each action is entered into the computer system via a display terminal and the appropriate service plan request is printed out. Typically, the client may be sent to the Division of Vocational Rehabilitation for his physical examination and evaluation, then to the HSD employment center for skills evaluation and training.

During the training period and when he begins his new job, the client's attendance and progress are monitored. While it is still too early to quantify the results of this approach, we are getting an increasing number of outreach followup reports coded "S"—indicating that the worker has become self-sufficient.

Thus, with central outreach staff in each neighborhood center handling recruitment, intake, diagnosis, surveying, and other functions, we have eliminated much of the duplication in supportive services. This permits the agencies to concentrate on their primary functions—direct services such as health, education, and training.

Nor must the agencies send their personnel into the field to gather readily available information. In the past, if the health department wanted to know the number of mothers interested in day care on a certain block, its own staff had to survey the block. Now, it can contact the Urban Management Information Office to obtain a list of homes with small children.

Response to telephone inquiries from various public and private agencies is even more prompt. The two terminals at one neighborhood center are staffed by operators with telephone headsets. They serve solely to provide basic data to the agencies, such a general family information about a client. However, built-in safeguards protect the confidentiality of certain data about each client unless he or she gives written permission for an agency to obtain the information.

As a byproduct of the stored information, the computer system produces a variety of daily, weekly, and monthly reports. The daily report, produced each evening, for example, lists contacts or referrals by agency, the number of workers involved, by agency, and totals for that day.

It is impossible to exaggerate the importance of the information the system is accumulating—information so basic, yet previously unobtainable with accuracy or in detail.

Until now, we have known little more about this group of citizens than its total number, and even that is suspect. As we build the data in the computer system, we should be able to determine who the jobless are, where they live, their education, skills, age, sex, color, how long they have been without jobs, and why.

As mentioned, human services information is only the first segment of our projected Urban Management Information system. Additional areas where the system can make a contribution include job bank information, veterans services, neighborhood city hall complaint processing, crime and social service statistics, terminals in hospitals, the Veterans Administration, and the like. We also would like to store the complete State welfare eligibility manual on the system, so that we could tell a client immediately if he were eligible for long-term aid, eliminating the need for many emergency services. But this will require legislative action.

Once this varied urban data is available in the system, the analytical possibilities are tremendous.

Most important, we will be able to get away from detailed examination of each welfare program and to make comprehensive studies of the total community impact of all our human services programs.

Mr. Walker is Mayor of Chattanooga, Tenn.

Research and Demonstrations

In some instances recent project reports can be obtained from the grantee (addresses given below). When the report is not available from the grantee, it may be purchased from the National Technical Information Service, Springfield, Virginia 22151 Remittances should accompany orders; prices are $3 for hard cover and $.95 for microfiche copies.

DEVELOPMENT OF RESEARCH UTILIZATION PROGRAMS. (RD55247) Missouri Section of Vocational Rehabilitation, State Dept. of Education, 1448 West Dunklin, Jefferson City, Mo. 65101. 67 pages.

BEHAVIORAL MANAGEMENT OF STUTTERING. (RD55281) University of Southern California, University Park, Los Angeles, Calif. 90007. 113 pages.

FITTING OF LOWER EXTREMITY PROSTHETICS. (RD55130) University of Virginia, Charlottesville, Va. 22903. 56 pages.

HANDEX APPALACHIAN PROJECT. (RD55052) HANDEX Corp., 41 E. 65th St., New York, New York 10021. 54 pages.

COMMUNITY PROGRAMS TO FACILITATE THE REHABILITATION OF PERSONS WITH EPILEPSY. (RD55072) Epilepsy Foundation of America, 1828 L St. N.W., Suite 406, Washington, D.C. 20036. 37 pages.

THE EFFECTS OF SURGICAL TREATMENT FOR FOCAL EPILEPSY. (RD-2341M) Division of Neurological Surgery, The Johns Hopkins University School of Medicine, 601 N. Broadway, Baltimore, Md. 21205. 33 pages.

LOW-BACK DISORDERS: PSYCHOLOGICAL, DEMOGRAPHIC, AND ORGANIC CORRELATES OF RESPONSE TO TREATMENT. (RD1817M) Orthopaedic Hospital, 2400 South Flower St., Los Angeles, Calif. 90007. 137 pages.

INTELLIGENCE TEST MODIFICATIONS ON HANDICAPPED AND NON-HANDICAPPED CHILDREN. (RD55277) San Diego State College Foundation, San Diego State College, San Diego, Calif. 92115. 73 pages.

STRATEGIES FOR WORKING WITH THE INNER-CITY POOR. (RD55205) Vocational Guidance and Rehabilitation Services, 2239 East 55th St., Cleveland, Ohio 44103. 37 pages.

IMPROVED DELIVERY OF HEALTH CARE TO THE MEDICALLY INDIGENT IN BEXAR COUNTY. (RD552381) Bexar County Hospital District, 4502 Medical Drive, San Antonio, Tex. 78284. 88 pages.

THREE DIMENSIONS OF A MODEL CITIES VOCATIONAL REHABILITATION PROGRAM: REHABILITATION GAIN, AGENCY-ENVIRONMENT INTERACTION, ORGANIZATIONAL STRUCTURE AND PROGRESSES. (RD55131) Model Cities, Social Services Vocational Rehabilitation, Virginia Dept. of Vocational Rehabilitation, 4615 West Broad Street., Richmond, Va. 23230. 199 pages.

REHABILITATION PROCESS IN CORRECTIONAL WORK RELEASE. (RD-55897) North Carolina Division of Vocational Rehabilitation Services. 12 pages.

HEALTH CARE UTILIZATION BY PERSONS WITH CHRONIC DISABILITIES WHO HAVE BEEN VOCATIONALLY REHABILITATED. (RD55710) Dept. of Physical Medicine and Rehabilitation, University of California-Davis, School of Medicine, Davis, Calif. 95616. 87 pages.

AN INDEX TO REHABILITATION AND SOCIAL SERVICES PROJECTS-VOLUME II 1955-73. (RD55142) Regional Rehabilitation Research Institute, University of Florida, College of Health Related Professions, J. Hillis Miller Health Center, Box 208, Gainesville, Fla. 32610. 218 pages.

REHABILITATION OF PATIENTS WITH MAXILLIFACIAL CANCER PROSTHESIS. (RD55069) Gonzalez Martinez Oncologic Hospital, Box 1811, Hato Rey, Puerto Rico 00919. 149 pages.

DEAFNESS ANNUAL VOLUME III. (RD55339) Professional Rehabilitation workers with the Adult Deaf, Inc., 814 Thayer Ave., Silver Spring, Md. 20910. 389 pages.

EVALUATION OF THE BINAURAL SENSOR IN REHABILITATION OF THE BLIND. (RD 55186) Department of Children and Family Services, 404 New State Office Building, Springfield, Ill. 62706. 44 pages.

THE REHABMOBILE: A MOBILE REHABILITATION CLINIC. (RD 3149) Albert Einstein College of Medicine of Yeshiva University, Bronx, N.Y. 10461. 25 pages.

The following reports on research in education may be ordered from ERIC Documentation Reproduction Service, Post Office Drawer O, Bethesda, Md. 20014. Microfiche (MF) copies are $.65 each. Hard copies (HC) are $3.29 each for reports of 1 to 100 pages; $6.58 each for reports of 101 to 200 pages; $9.87 for reports of 201 to 300 pages; and $3.29 for each additional 100 pages or portion thereof. Order by accession number (in parentheses) and make checks payable to EDRS. Official institution, State and Federal Government, and company purchase orders are accepted.

BUILDING COMMUNICATIONS SKILLS: HOME-SCHOOL-COMMUNITY. (ED075689) Florence-Firestone Project, Los Angeles Unified School District, California. 314 pages.

PRIVATE OUTDOOR RECREATION ENTERPRISES IN RURAL APPALACHIA. (ED075705) Economic Research Service (DOA) Washington, D.C. 21 pages.

DISCUSSIONS YOU CAN LEAD: A GUIDE FOR DISCUSSION LEADERS. (ED075706) Massachusetts University, Amherst, Labor Relations and Research Center. 50 pages.

MENTAL HEALTH: PRINCIPLES AND TRAINING TECHNIQUES IN NURSING HOME CARE. (ED075713) National Institute of Mental Health, Rockville, Md. 100 pages.

CONTEMPORARY APPROACHES TO PROGRAM EVALUATION AND THEIR IMPLICATIONS FOR EVALUATING PROGRAMS FOR DISADVANTAGED ADULTS. (ED075715) Syracuse University, New York. 266 pages.

FROM HOSPITAL TO COMMUNITY: A SELF-HELP PROGRAM TO PROMOTE THE TRANSITION. (ED075721) Yeshiva University, Bronx, N.Y., Albert Einstein College of Medicine. 122 pages.

Does City Living Damage Kids' Minds?

ABRAHAM S. LEVINE, PH.D. and MARLA B. KAHN

Since little is known about mental disorders among children from different socioeconomic statuses, the Social and Rehabilitation Service (SRS) through its Office of Research and Demonstrations and the National Institutes of Health supported a study in this area. We wanted to know how mental disorders affected children from different socioeconomic and ethnic groups. The knowledge could become a basis for mounting programs to ameliorate conditions which perpetuate dependency and misery. A full discussion of this may be found in Thomas S. Languer's article, "Children of the City: Affluence, Poverty, and Mental Health" published in *Psychological Factors In Poverty* by Markham Publishing Company of Chicago. Many publications document the incidence of greater physical disorders among the poor. This study is a pioneering attempt to consider the psychological disadvantages.

About 400 children were selected from a random sample of over 1,000 households on the East and West Sides of Manhattan Island, New York. Their ethnic distribution: 65 percent white, 16 percent black, and 14 percent Puerto Rican. Average age was 11.7 and there were about an equal number of boys and girls.

They covered the entire income range, but average income is deceptive since about 32 percent of the families earned over $15,000. Another large group occurred around $4,000. What this points out is that large cities are fast becoming the havens of the rich and the poor with middle income groups fleeing to the suburbs.

The data revealed that 46 percent of the mothers and 91 percent of the fathers were employed. A fact which will become even more significant later on as the findings are uncovered is that among the high-income blacks (over $15,000) both mothers and fathers worked far more often as compared to high-income whites, where typically only the male worked. In making comparisons, low-income families were those making less than $6,500 a year. A disproportionately high number of families made over $15,000 a year ("high income").

The mother of each child in the sample was interviewed by a psychiatric social worker from Columbia University or someone of equivalent training. The interview was comprehensive and took about 2 hours. The following areas were particularly well covered: child's current behavior with family, friends, and in school. Symptoms regarded as significant were those which might be considered neurotic, psychotic, psychophysiological (*e.g.*, mental retardation), and sociopathic. The child's medical history, going back to mother's pregnancy, was surveyed. Also covered were parental practices, their attitudes, backgrounds, and relationship to one another. The psychotherapeutic background of all members of the family received special attention.

A special computer program produced three printed reports of the questionnaire data: 1) Symptoms of the child, 2) social background (ethnicity, income level, religion, etc.) and 3) parental practices and attitudes.

One psychiatrist examined the child directly, and two rated him from the report produced by the examiner. All mothers were interviewed. High rater agreement was obtained.

The first rating permits correlating social data with impairment. The second allows the clinician to take into account mitigating circumstances which are external, such as an immigrant child with a language difficulty. In the third rating, an attempt is made to obtain what a total psychiatric evaluation might be if all the information were provided. Such a rating tends to be closest to a direct examination, using all the clues.

A five-point impairment scale was developed and used: 1) Well-to-minimal, 2) mild, 3) moderate, 4) marked,

and 5) severe-to-incapacitated. All of the children were rated on this scale.

Another approach to the distinction between health and illness is made through a "caseness rating." Along with each impairment rating a caseness rating was obtained. This is also expressed on a five-point scale but represents in percentage terms the confidence of the psychiatrist (10, 25, 50, 75, and 90 percent) that there should be some form of therapeutic intervention in the child's situation. This gives the rate of potential "cases."

Of course, impairment and caseness are not identical. For example, a child may show little overall impairment, but he might have first-grade reading difficulties caused by sensory problems. Impairment might be rated only as moderate, yet caseness would be high, perhaps 90 percent.

Only 1 percent suffered from such brain defects as pronounced mental retardation due to a physiological deficit.

Another serious category is the 5 percent assessed as having psychotic disorders. Only 8 percent of the children were considered neurotics, but unexpectedly a large group (45 percent) exhibited personality trait disorders. Many child psychiatrists are of the opinion that the presence of well-crystallized, neurotic-like symptomatology in children is indicative of a profound defect in personality; to be so fixed in adaptive modes at an early age indicates an underlying psychotic process.

On a pilot sample of 54 cases of mothers who were selected for home visits by the psychiatrist, the mother's total impairment was shown to be highly related to the child's total impairment.

A father's absence from the home shows a strong and definite relationship to the child's impairment. These children were worse off than those with fathers, in almost every impairment area, whether they were boys or girls. Of great theoretical and practical significance, however, is the finding that the presence of a surrogate father, such as a stepfather, seems associated with greater impairment than that found with the father merely absent but not replaced. Explanation of this facet should receive additional research since it may be only peculiar to this sample.

Homes wracked by quarrels produce greater impairment in their members than those broken by death.

Interruption of maternal care is also a factor. Significant impairment is found in about 20 percent not in mother's care since birth, compared to 12 percent receiving such care. This finding argues for services to keep children in their own homes.

A parent's lack of education is dramatically related to the child's impairment. There is a direct-line relationship with 21 percent of children from grammar-schooled mothers to only 4 percent whose mothers had a graduate school education. The father's education shows a similar trend.

Boys showed a greater proportion of 4 plus impairment (marked or severe) than girls (16 percent versus 10 percent). This is in accord with most studies of people who have received psychotherapy, which indicates that boys in treatment outnumber girls by two or three to one.

Differences among children of various income groups indicated a *much greater impairment among children from lower income families.* This finding has been repeated in most of the 20 or so studies on mental disorders among adults that have been examined in which there have been made socioeconomic comparisons. Of the children in the higher income group, 8 percent were impaired as compared to 20 percent of the low-income group. These mirror the impairment of adults who are their parents. If these figures stand up, a child whose parents are in a low-income bracket compared to that of a child whose parents are in a high-income bracket, has twice the chance of being mentally impaired. An exception occurs when a child is black.

Ethnicity is extremely significant in impairment. Data showed that there is a distinct income difference within the white group, where 20 percent of the low-income whites showed marked impairment or worse. But in blacks there are no real differences in impairment between low-income families (18 percent of children) as compared to 19 percent of children from high-income families. One explanation for this finding is prejudice and job discrimination, which in turn may affect family relationships. This may also be true of Spanish-speaking children where high-income families show a 15 percent impairment rate as compared to 17 percent in their low-income peers.

In the "blind" ratings of high-in-

come families considered separately, which were taken from printouts alone, there was evidence of significant impairment only in high-income black children. It is interesting that discrimination affects even the higher-income blacks, which robs the family of cohesion and has its repercussions in interpersonal and parent-child conflicts.

Black marriages were most likely to be reported as least happy. The mother was most likely to be "boss of the family," but least likely among the Puerto Ricans or the "Spanish." There were equal proportions of fathers and mothers acting as "boss" among black families, while twice as many fathers were boss among low-income whites, four times as many among high-income whites, and seven to eight times as many among the Puerto Ricans.

There is little doubt that the mass of foregoing evidence shows that low socioeconomic status and minority ethnic background are associated with greater psychiatric impairment in urban children. It is also suggested that an increase in family income at the expense of having both parents work full time, without improvement of parental education or without social acceptance of the family in the wider community is not enough to reduce impairment among black and possibly Puerto Rican children.

Dr. Levine is Chief of the Child Welfare Research Branch in SRS headquarters. Miss Kahn is a professional staff assistant in the same branch.

People Make the Difference for ACTION

MICHAEL BALZANO, PH.D.

The "new federalism," which has been an important part of the Nation's mood these past few years, requires a return of power to the people; and consequently that entails an increased use of volunteers in the delivery of social services.

The present federal administration has been a strong advocate of voluntarism. In 1971, the President supported the creation of the National Center for Voluntary Action, an organization dedicated to voluntarism in the private sector.

In the public sector, there are also numerous federal volunteer programs, but these have been dispersed among many government agencies, creating a tendency for duplication. Thus, in 1971, the President placed the voluntary programs in a single agency called ACTION. The principal purpose for the creation of this new agency was to develop a coordinated voluntary effort which, in the President's words, would "forge an alliance of the generations" for the solution of the pressing social problems of our Nation.

ACTION, therefore, became an organization which represented thousands of dedicated volunteers and the people they serve in communities across the United States. This umbrella program represented and became supportive of a variety of volunteer programs in sometimes diverse areas, such as:

- VISTA people who are transferring their skills, energy, and enthusiasm to the residents of poverty-stricken urban and rural areas.
- UYA volunteers who are bringing the energies of young students and the resources of the university to bear on the problems of the poor in a tested new application of the basic VISTA model.
- Older Americans who are serving as Foster Grandparents and Retired Senior Volunteers, thus filling the vacuum of needed one-to-one companionship for thousands of handicapped children, while at the same time adding new meaning to their own lives through a renewed sense of usefulness in our society.
- SCORE and ACE volunteers who draw on expertise gained from long and successful business careers to help prevent small business failures in the country.

ACTION's operations during the first two years of its existence have enabled us to marshall and develop new ways to apply the enormous reservoir of volunteer energies available today in America. When the federal volunteer programs were merged under a single management, one of the first benefits we anticipated was a greater inter-program cooperation among volunteers from different programs, a hope already realized in a number of cases.

ACE volunteers are assisting VISTA workers establish a factory in Cumberland, Virginia.

UYA volunteers have often been the catalyst for Foster Grandparent and RSVP programs.

Hurricane Agnes brought VISTA and SCORE volunteers together for relief and cleanup jobs in Harrisburg and Wilkes-Barre, Pennsylvania.

A second objective was the stimulation of new opportunities for volunteers to serve and new ideas for the mode of service. And this, too has been achieved.

The University Year for ACTION program, which was launched shortly after ACTION's inception, has been flourishing ever since, and we estimate that by the end of this fiscal year we will have 1,700 student volunteers taking up the challenge of learning outside of the confines of the classroom while at the same time providing substantial benefits to the poor in the communities they serve.

ACTION is continuing to initiate other pilot efforts, and we are confident that we will be able to duplicate the success of UYA.

A third major objective of ACTION was the development of an effective mechanism which would strengthen the merged programs. We have accomplished this in a number of gratifying instances:

We have established ACTION-wide program offices in most states. These offices are inherently structured so that they will be closer to the communities served, the various projects, and the volunteers themselves, thereby insuring the responsiveness of the Agency and the programs to the needs of those being served. In many cases this has entailed assisting various communities in the development of a precise application of the program to the specific conditions of the individual community and State.

New VISTA criteria have been implemented which guide the program development process so that projects and volunteer activities will be goal-oriented. A new priority has also been given to the participation of locally recruited volunteers and the involvement of the target community in project planning.

The Retired Senior Volunteer Program has been strengthened by the 2-year State Development grants which have brought both the message of the program and procedure for enlistment to every part of the State. This has resulted in the enlistment of over 18,000 older American volunteers in over 307 programs.

The fourth major objective at ACTION's inception was improved efficiency in the various programs through the consolidation of recruitment activities and other services, and to date we have made progress:

The reduction of program costs, for instance. We have calculated that if recruitment were still carried on separately by Peace Corps and VISTA in FY 1974, the total recruiting operation would cost about $13 million. But now we are currently estimating that the consolidated recruiting operation will cost only a little over $7 million, a savings of almost $6 million, or 46 percent.

ACTION's consolidated recruitment effort has also been especially responsive to the needs of special groups of Americans. Successful and continuing efforts have been made to encourage minority participation in ACTION service programs. Furthermore, particular attention has been paid to recruiting our Nation's veterans, with the result that some 550 veterans have begun Peace Corps or VISTA service in the past year.

These are all heartening accomplishments of ACTION's first 2 years—the progress in the growth of the volunteer programs themselves, progress in the development of administrative systems to support these programs, and the encouragement of

creative cross-fertilization and cooperation between them—but, nevertheless, much remains to be done.

At the time of my appointment as Director of ACTION, the President gave me instructions to broaden the base of the federal volunteer effort, both in terms of program participants and in terms of those served by ACTION's programs. The President expressed his concern that the full potential of voluntarism in America was still untapped, and I was asked to find new ways of calling more of the mainstream of America into volunteer service.

On the international side, the President expressed his concern that the great gains made with respect to reducing tension in the international environment should not be lost, and he stressed the importance of maintaining and improving upon the operations of the Peace Corps. On the domestic front, he stressed the need to move decisively to bring even greater actualization to all of the benefits which were initially envisioned in the creation of the new agency.

The President expressed a desire for State and local governments to have a greater input in the federal programs which affect them, particularly on the community level, and he stated his belief that those in the community who are closer to the problems often understand those problems and possible solutions better than administrators who live in Washington, D.C.

At the time of my appointment as Director, I had the advantage of having served as an advisor to the Director of ACTION when the new agency was initially created. Using this past experience and the President's ideas, we were able to make a full assessment of ACTION's past accomplishments and future directions.

In the area of policy formulation, we have now created a policy council consisting of the Regional Directors and the Director. This will allow the Regional Directors, who live in the field and who are close to the problems, to bypass the entire federal bureaucracy in order to present ideas and suggestions which affect the range of policies of our agency.

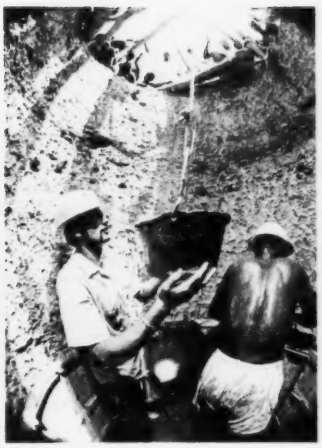
We have also established a revised statement of ACTION goals for the agency:

1. To mobilize volunteers to participate in the innovative efforts of state and local governments, communities and institutions to solve local social and economic problems, particularly by strengthening and supplementing efforts toward helping the poor to overcome the handicaps of poverty.

2. To support those programs of local governments, communities and institutions which will call upon volunteers to demonstrate new ways of solving community problems, particularly those related to poverty, and will lead to a continuing effort supported by local resources.

3. To increase the participation in volunteer antipoverty and other community improvement projects of the full range of community organizations.

4. To stimulate interest by the local citizenry to join in the efforts to solve local problems, particularly those related to poverty, and to gen-



erate such interest by allowing local citizens greater input into the design and operation of programs.

5. To increase the relevance of volunteer activity to efforts to solve the problems of local communities, particularly those related to poverty, by generating and utilizing greater numbers of community volunteers serving in their own communities and drawn from all quarters of the community.

6. To create and stimulate new approaches to voluntarism which demonstrate the potential of volunteers as a resource for the solution of problems arising out of poverty and other human needs.

The major objective behind these ACTION goals is the development of more opportunities for all those who want to serve in their community. We are seeking a broader participation in voluntarism on the part of all Americans, not only in the number of those who serve, but in the number of those who are served and the range of services which are offered to them. We are seeking to design a program which is flexible enough to encompass a wider range of social needs; a program inventive enough to strengthen efforts towards overcoming handicaps of poverty; a program responsive enough to utilize volunteers in other areas of human and social needs. And, we are also seeking the decentralization of power and authority in decision-making so that we can place the decisions in the hands of local citizens and local officials.

If we can do this, then we will see ACTION's projects serving many more communities than they now serve, and these projects will operate more broadly in every community to meet instant needs as they are encountered. And we will see ACTION volunteers and officers drawing skillfully and imaginatively upon the full range of resources available in the community. And finally we will see a greatly increased participation of citizens from all walks of life in the design and implementation of volunteer programs.

The impulse for volunteer service is a strong one in America, and we must utilize it in the delivery of social services. ACTION's mail is bursting with new ideas directed to us by Americans from all over the country —ideas which seek to address the problems which afflict the poor, but ideas which reach beyond the strict definitions which have been used to describe poverty over the past eight years. These ideas, and the good will and voluntary service of the people who present them, can be used to serve the needs of many more people in the years ahead.

ACTION, if it receives the enabling legislation and budget approval, hopes to have almost 125,000 domestic volunteers by the end of FY 1974. More than 7,000 of these people will be serving in a full-time capacity, while the rest of them will be applying their energies and talents on a part-time basis. But all of them will be a part of the ongoing effort to marshall the willingness of Americans of all ages, backgrounds, and skills in freely contributing their services to less fortunate Americans.

Dr. Balzano took office as the Director of ACTION on May 14, 1973.

Each month the SOCIAL AND REHABILITATION RECORD will carry a listing of SRS administrative issuances for previous months. Over the course of a year, the RECORD will have presented a complete bibliography of administrative issuances for the year.

The following are the administrative issuances for the months of October and November 1973. (Abbreviations key: **PR**-Program Regulations; **PRG**-Program Regulations Guides; **PI**-Program Instructions; **IM**-Information Memoranda; **FSI**-Field Staff Information and Instruction Series; **AO**-Administrator's Office; **MSA**-Medical Services Administration; **APA**-Assistance Payments Administration; **CSA**-Community Services Administration; **RSA**-Rehabilitation Services Administration; **NCSS**-National Center for Social Statistics.)

When ordering reports, please specify the appropriate room number for the particular report: For NCSS reports, write NCSS Reports Clerk, Room 2620; for PR reports, write PR Reports Clerk, Room G-115B; for AO reports, write AO Reports Clerk, Room G-115B; and for all other reports, write Reports Clerk, Room 5219.

Send all requests with the appropriate room number to Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 330 C Street S.W., Washington, D.C. 20201.

APA-PI-74-5: State Plan Amendment Preprint—Disregard of Income & Resources: Judgment Payments to Certain Indian Tribes and Nutrition and Volunteer Programs of Older Americans Act (10/15/73)

APA-PI-74-6/PS & DS-NCSS-PI-74-11: WIN Monthly Program Activity Summary SRS-NCSS-117-Project Numbers (11/24/73)

APA-IM-74-2: WIN Y USTED: Spanish Language Version of WIN and YOU (11/8/73)

APA-IM-74-3: Choice of Program for Persons Eligible For Benefits Under Both Title IV and Title XVI (11/13/73)

AO-IM-74-20: Payments for Chiropractor's Services (10/9/73)

AO-IM-74-21: Establishing Paternity and Securing Support for Children Receiving Aid to Families with Dependent Children (AFDC) (10/4/73)

AO-IM-74-22: Additions to the Compilation (11/2/73)

AO-IM-74-23: Medicaid Eligibility Under Supplemental Security Income Program (11/21/73)

PR 30-4(C-3): Modification of Social Services Regulations (10/31/73)

PR 10-11(C-13): Citizenship and Alienage (11/2/73)

PR 10-7(C-1)&20-2(C-1): Recipient Count-Federal Financial Participation (11/29/73)

MSA-IM-74-7: Policies and Procedures Regarding Methods for Determining Compliance with Title VI of the Civil Rights Act of 1954 by Skilled Nursing Facilities and Intermediate Care Facilities (10/17/73)

MSA-IM-74-8: AMA Committee on Health Care of the Poor Symposium on Professional Health Provider Participation in EPSDT—Summary Statement & Recommendations (11/28/73)

MSA-PI-74-2: Preprinted State Plan, Form Attachments, and Instructions for preparation and submittal. This plan includes provisions of P.L. 92-223, P.L. 92-603, and of P.L. 93-66—except those for which the Secretary must prescribe standards or conditions (such as the mandatory premium or enrollment fee for the medically needy), and those that are effective January 1, 1974 or later. Revised pages will be issued when required by regulations published in the future, including those implementing the remaining statutory provisions.

Conversion to preprinted format is in keeping with recent efforts toward plan simplification and elimination of excessive processing of plan material (10/15/73)

MSA-PI-72-2a: Preprinted State plan-revised pages. The preprinted plan transmitted to State Agencies by MSA-PI-74-2 dated October 15, 1973, inadvertently omitted several lines from section 5.1, Standards of Personnel Administration (page 26). Attached for substitution is the correct version (10/23/73)

MSA-PI-74-3: Preprinted State plan for Medical Assistance Programs under Title XIX. Revised pages, as indicated in attached outline, and instruction with respect to several procedural questions raised (11/28/73)

MSA-PIM-74-4: Secretary's Decision on Federal Fiscal Liability for Erroneous SSI State Supplement Payment and Medicaid Determinations (11/19/73)

MSA-PIM-74-5: Policy and Implementation of the "Past-Along" Provisions of P.L. 91-172 & P.L. 92-603 (11/28/73)

MSA-PRG-No. 29: MSA Medical Assistance Manual: Reasonable Charges Amendment: Inpatient Hospital Services (10/5/73)

MSA-FSI-74-25: Economic Stabilization Program (10/5/73)

MSA-FSI-74-26: Additional Surveyor Courses at U.C.L.A. (10/5/73)

MSA-FSI-74-27: Contract SRS 72-57, A Study of the Buy-In Provisions of the Medicaid Program—Distribution of Final Report (10/15/73)

MSA-FSI-74-28: Professional Medical Review Workshops (10/15/73)

MSA-FSI-74-29: Additional PSRO Information (10/23/73)

MSA-FSI-74-17-A: Medicaid Financial Review Objective—Instructions and Suggestions for High Payoff Activity (10/19/73)

MSA-FSI-74-30: Cuba Checkerboard Rural Health Project—Filmograph (10/24/73)

MSA-FSI-74-31: Burke Day Hospital Film (10/26/73)

MSA-FSI-74-32: Interim Procedures for Issuing Time-Limited Agreements to SNFs (11/8/73)

MSA-FSI-74-33: Title XIX Preprinted State Plans and Amendments—SRS Regional Office Procedures for Review and Action (11/12/73)

MSA-FSI-74-34: Personal Needs Allowance to Institutionalized Title XIX Patients; Eligibility of Institutionalized Patients for $20 SSI Income Disregard (11/21/73)

MSA-FSI-74-35: OPSR Memo—November 1973 (11/21/73)

RSA-IM-74-17: Distribution of the "Quarterly Status Report of Social Security Disability Insurance Beneficiaries" Quarter Ending June 30, 1973 (10/3/73)

RSA-IM-74-18: Program Plans for Rehabilitation Facility Reporting (Reciprocal Rehabilitation Reporting System) (10/4/73)

RSA-IM-74-19: Receipt of Minor Medical Services (MMS) by participants in the Manpower Development and Training Act Program, Fiscal Year 1973 (10/9/73)

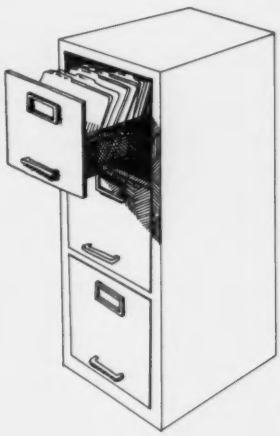
RSA-IM-74-20: Number of Rehabilitations: July to July 31, Fiscal Years 1973 and 1974 (10/15/73)

RSA-IM-74-21: Number of Rehabilitations: July 1 to August 31, Fiscal Years 1973 and 1974 (10/18/73)

RSA-IM-74-22: Distribution of "A Profile of Rehabilitated Clients By Sex, Fiscal Year 1971" (10/18/73)

RSA-IM-74-23: *Hiring Persons with Hearing Impairments* Published by the President's Committee on Employment of the Handicapped (10/26/73)

RSA-IM-74-24: Services to the Blind: A Community Concern; A Training Resource Document Developed by the Eleventh Institute on Rehabilitation Services (11/2/73)



RSA-IM-74-25: FY 1974 Rehabilitation Training (11/6/73)

RSA-IM-74-26: Distribution of "A Profile of Drug Addicts Rehabilitated During Fiscal Year 1971" (11/9/73)

RSA-IM-74-27: Appropriation request for FY 1974 (11/9/73)

RSA-IM-74-28: Annual Report, "Characteristics of Clients Rehabilitated in Fiscal Years, 1968-1972" (11/23/73)

RSA-IM-74-29: Number of Rehabilitations: July 1 to September 30, Fiscal Years 1973 and 1974 (11/23/73)

NCSS-IM-74-2: 1973 AFDC Study Punched Cards (10/29/73)

NCSS-IM-74-3: 1973 AFDC Study: Followup of Case Discontinued During FY 1973 (11/7/73)

NCSS-74-8: Federal Vocational Rehabilitation Manual—Chapter 13, Section II, Form SRS-RSA/300 Case Service Report, Item 2L, Total Number in Family Items, 2R (10/4/73)

NCSS-PI-74-9: Annual Report on Methods of Dealing with Questions of Recipient Fraud in State Public Assistance Programs, Form SRS-NCSS-110, (11/1/73)

NCSS-PI-10: Data on AFDC Recipients Needed to Implement the Elementary and Secondary Education Act for Fiscal Year 1974 (11/8/73)

NCSS-IM-74-11: WIN Monthly Program Activity Summary SRS-NCSS-117 Project Numbers (11/11/73)

NCSS-PI-74-12: Semiannual Statistical Report on Fair Hearings in Public Assistance (Including Medical Assistance), Form SRS-NCSS-105 (11/30/73)

NCSS-PI-74-13: Monthly Statistical Report on Medical Care, Form SRS-NCSS-120 (11/30/73)

Career Opportunities

NUTRITION CONSULTANT. Bachelor's degree from an accredited 4-year college or university with specialization in nutrition or institutional food management. Five years of progressively responsible experience in the supervision or administration of institutional food management programs. Experience may be substituted for educational requirements on a year-for-year basis. $195.70—237.70 per week. Write: Examination Div., Dept. of Personnel, State House, Augusta, Me. 04330.

DIRECTOR, SPECIAL SERVICES. Bachelor's degree in journalism, English or other closely allied field. At least 6 yrs. of experience in public relations work. Administrative experience is essential. Equivalent experience may be substituted for educational requirements on a year-for-year basis. Copies of transcripts must be submitted with application. $237.70—289.00 per week. Write Examination Div., Dept. of Personnel, State House, Augusta, Me. 04330.

EXECUTIVE DIRECTOR. Master's degree, training and/or experience in mental retardation and administration. Training and experience in related fields considered. $20,000—25,000. Write: Maxine Mays, 102 St. James Place, Buffalo, N.Y. 14222.

REGISTERED NURSE. Applicants must be currently licensed with the Maryland State Board of Examiners of Nurses. Experienced. $9,800—13,875. Write: Mr. Lowell N. Dykes, Personnel Officer, Maryland Rehabilitation Center, 2301 Argonne Drive, Baltimore, Md. 21218.

REGISTERED NURSE. Applicants must be currently licensed with the Maryland State Board of Examiners of Nurses. $8,906—11,039. Write: Mr. Lowell N. Dykes, Personnel Officer, Maryland Rehabilitation Center, 2301 Argonne Drive, Baltimore, Md. 21218.

LICENSED PRACTICAL NURSE. Experienced. Applicants must be currently licensed with the Maryland State Board of Examiners of Nurses. $7,201—9,462. Write: Mr. Lowell N. Dykes, Personnel Officer, Maryland Rehabilitation Center, 2301 Argonne Drive, Baltimore, Md. 21218.

LICENSED PRACTICAL NURSE. Applicants must be currently licensed with the Maryland State Board of Examiners of Nurses. $6,667—8,761. Write: Mr. Lowell N. Dykes, Personnel Officer, Maryland Rehabilitation Center, 2301 Argonne Drive, Baltimore, Md. 21218.

OCCUPATIONAL THERAPIST. 1-year exp. Must be registered or eligible for registration by AOTA. $9,800—12,875. Write: Mr. Lowell N. Dykes, Personnel Officer, Maryland Rehabilitation Center, 2301 Argonne Drive, Baltimore, Md. 21218.

OCCUPATIONAL THERAPIST. No exp. Must be registered or eligible for registration by AOTA. $8,401—11,039. Write: Mr. Lowell N. Dykes, Personell Officer, Maryland Rehabilitation Center, 2301 Argonne Drive, Baltimore, Md. 21218.

ACCOUNTING CLERK I. Graduation from HS or GED certificate including coursework in bookkeeping or an equivalent combination of training and experience. $5,214—6,992. Write: State Personnel Office 1228 N. Scott Street, Wilmington, Del. 19806.

Mail your agency's classified listings to Editor, SOCIAL AND REHABILITATION RECORD, DHEW-SRS, Washington, D.C. 20201. Applicants should apply directly to the hiring agency, NOT this magazine. No "situation wanted" or non-governmental listings accepted. There is no charge or fee of any kind for this service.

ACCOUNTING CLERK II. Graduation from HS or GED certificate, including coursework in bookkeeping, and 1 year of bookkeeping experience; or an equivalent combination of training and experience. $5,741—7,714. Write: State Personnel Office. 1228 N. Scott Street, Wilmington, Del. 19806.

ACCOUNTING CLERK III. Graduation from an accredited school with an associate degree in accounting, bookkeeping, or business studies; or graduation from HS or GED certificate and 2 years of bookkeeping experience; or an equivalent combination of training and experience. $6,347—8,501. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19086.

ACCOUNTANT II. Bachelors degree in business administration with emphasis on accounting and 1 year of professional accounting expereince; or graduation from an accredited school with an associate degree in accounting, bookkeeping, or business studies and 3 years of experience; or graduation from high school or GED certificate and 5 years of experience; or an equivalent combination of training and experience. $9,437—13,356. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

ACCOUNT I. Bachelors degree in business administration with emphasis in accounting; or graduation from an accredited school with an associate degree in accounting, bookkeeping, or business studies and 2 years of professional accounting experience; or graduation from high school or GED certificate and 4 years of experience; or an equivalent combination of training and experience. $7,724—10,937. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

DIRECTOR OF ALCOHOL AND DRUG ABUSE. Masters degree in one area of the human services discipline preferred and 7 years of progressively responsible experience in functions related to alcohol and drug abuse problems such as social, legal, economic, and psychological considerations. Equivalent experience may be substituted for educational requirements on a year-for-year basis. $237.70—289.00 per week. Write: Department of Personnel, State House, Augusta, Me. 04330.

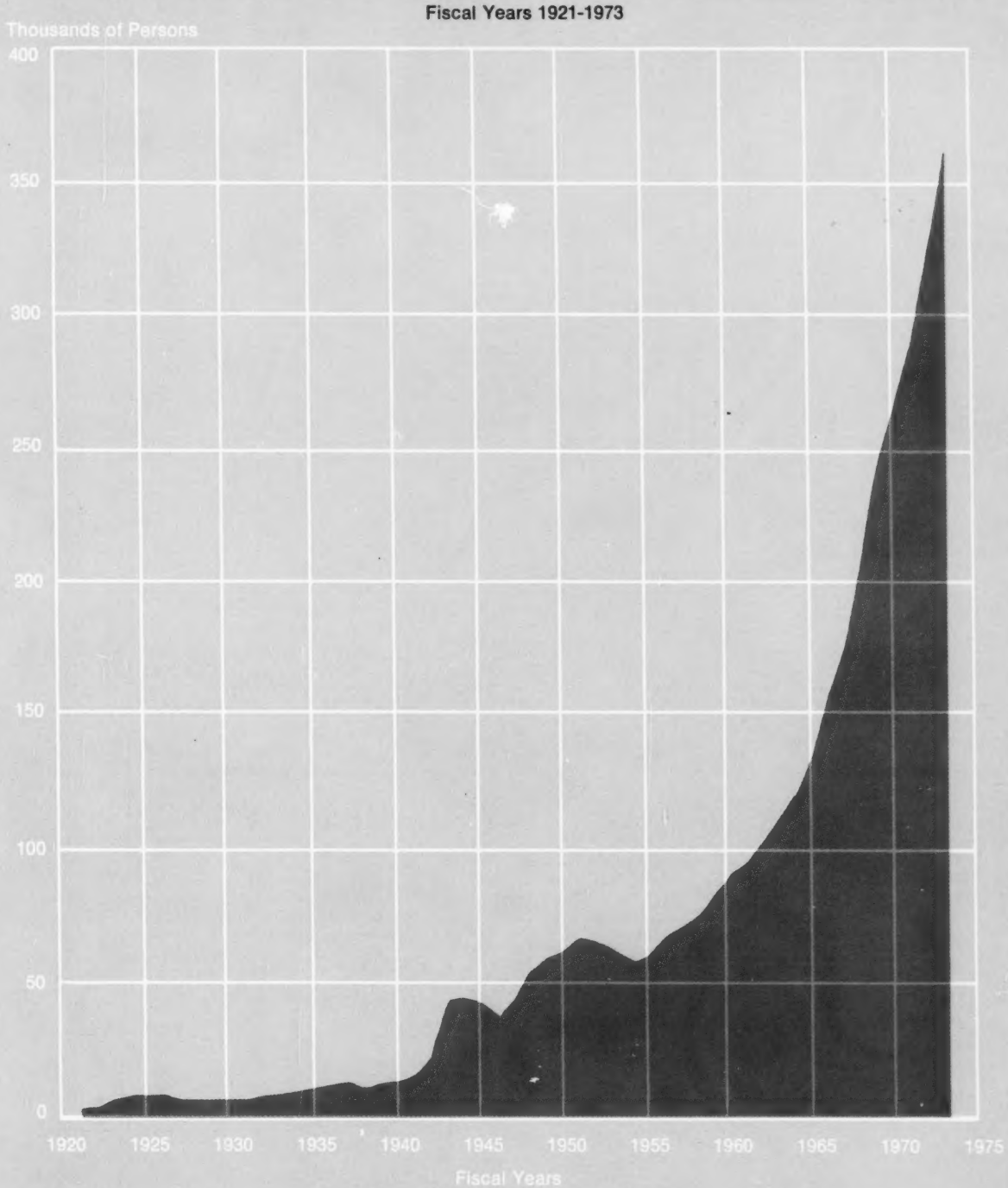
ACCOUNTANT III. Bachelors degree in business administration. Emphasis on accounting and 2 years of professional accounting experience; or graduation from an accredited school with an associate degree in accounting, bookkeeping, or business studies and 4 years of experience; or graduation from high school or GED certificate and 6 years of experience; or an equivalent combination of training and experience. $11,466—16,128. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

DRUG ABUSE ASSISTANT. Eighteen months of direct work experience with drug addicts and/or as a resident with supervisory responsibility in an approved residential or therapeutic community rehabilitation program. Salary $6,783-$9,156. Write: N.J. Dept. of Civil Service, Arnold Constable Bldg., Front & Montgomery Streets, Trenton, N.J. 08625.

Statistical Notes

Number of Persons Rehabilitated by State Vocational Rehabilitation Agencies

Fiscal Years 1921-1973



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